Hemlibra Referral Form

Date:_____

Evolutionary Pharmacy Solutions

Fax Referral To: 1-800-239-0363
Phone: 1-844-800-5377

EPSRX

PATIENT INFORMATION:

Last Name:	First Name:	Home Phone:	Mobile:		
Home Address:		City:	State:	Zip:	
Shipping Address:		City:	State:	Zip:	
Date of Birth:	Gender:	Language:	Email:		
Caregiver Name		Relationship:	Number:		

HEATLHCARE PROVIDER INFORMATION

Practice Name:	Dr Name:	Phone:	Fax	
Address:	City:	State:	Zip:	
NPI:	DEA:	License:	UPIN:	

INSURANCE INFORMATION *Provide Copy of Front & Back of Insurance Card *

Insurance Name:	Insurance Name:	
ID Number:	ID Number:	PCN:
Group Number:	Group Number:	BIN:

CLINICAL INFORMATION * Provide Medical Records *

Diagnosis:	**Severity:** ☐ Mild ☐ Moderate ☐ Severe	**Inhibitor Hx**: ☐ None ☐ Past Inhibitor ☐ Current _____BU/ml
Weight:	Height:	Allergies:
Access: ☐ Port ☐ PICC ☐ Central Line ☐ Peripheral ☐ Subcutaneous ☐ Other:		Hemlibra Pt: ☐ New ☐ Continuation ☐ Stabilized
Therapy: ☐ Prophylaxis ☐ Failed Immune Tolerance Therapy (List Previous Treatment):		

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Directions	Quantity	Refills
☐ Hemlibra (emicizumab-kxwh)	☐ 30mg/ml (30mg/ml) ☐ 60 mg/0.4ml (150mg/ml) ☐ 105 mg/0.7ml (150mg/ml) ☐ 150 mg/ml (150mg/ml)	☐ 3 mg/kg once weekly x 4 weeks ☐ 1.5 mg/kg once weekly ☐ 3 mg/kg once every 2 weeks ☐ 6 mg/kg once every 4 weeks		
Breakthrough Bleed Treatment				
☐ By-passing Agent:	Mild Bleed:			
	Severe Bleed:			
☐ On-Demand:	Mild Bleed:			
	Severe Bleed:			
☐ Other:				
☐ Emla ☐ LMX	Apply topically as needed to IV site 30-60 minutes prior to insertion prn.			

Flushes: ☐ Sod Chloride 0.9% 5ml ☐ Sod Chloride 0.9% 10ml ☐ Heparin 10 units/ml ☐ Heparin 100 units/ml **Directions:** Flush per protocol

Ancillary Supplies: ☐ As needed for administration and disposal of medications (alcohol wipes, gauze, sharps, transfer needle/syringe, inj needle,etc).

Patient Training: ****ALL INITIAL HEMLIBRA TRAINING WILL BE COMPLETED AT PRESCRIBING PROVIDER'S OFFICE ****

Patient/Caregiver is proficient in: ☐ Plan of Action for Bleed Treatment ☐ Drawing up Correct Dose ☐ Sterile Technique ☐ SubQ Administration ☐ Understanding Wastage in Vial ☐ Plan of Action for Side Effects ☐ Plan of Action for an Emergency ☐ Hemlibra Contact Information

Nursing Coordination:
☐ **YES:** Pharmacy to coordinate home health nursing visit as necessary (for additional education/training and/or to administer medication to patient)
☐ **NO:** Nursing not necessary:☐ Patient and/or caregiver are proficient with infusion ☐ MD Office to administer ☐ Nursing already established

Treatment Setting: ☐ Patient's Home ☐ Physician's Office ☐ Only Loading Doses at Physician's Office, then at Patient Home
☐ Other: _____ ☐ Requested Start Date:_____ ☐ Delivery To: _____

PRESCRIBER SIGNATURE: _____ **DATE:**_____
Verbal Readback ☐ Yes ☐ No ***Stamp signature not allowed, physician signature required ***